No. 82-292

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In the Supreme Court of the United States

OCTOBER TERM, 1982

CONSULTANTS AND ADMINISTRATORS, INC.,
an Illinois corporation,

Petitioner,

v.

DEPARTMENT OF INSURANCE OF THE STATE OF ILLINOIS, PHILIP R. O'CONNOR, Its Director, and ILLINOIS VISION SERVICES PLAN,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE APPELLATE COURT OF ILLINOIS, FIRST DISTRICT

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QUESTION PRESENTED

This case presents an important issue involving federal preemption: whether, in light of the express federal preemption of any state regulation which "relates to an employee benefit plan" contained in the Employee Retirement Security Act of 1974 ("ERISA"), the Appellate Court of Illinois improperly upheld the Illinois Department of Insurance ruling that the Illinois Voluntary Health Services Plans Act applied to the petitioner's acts, as an agent and "named fiduciary" of an employee benefit plan subject to regulation under ERISA, in setting up and administering a dental and vision care facility.

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PETITION FOR A WRIT OF CERTIORARI TO THE APPELLATE COURT OF ILLINOIS, FIRST DISTRICT

Petitioner, Consultants and Administrators, Inc., petitions for a writ of certiorari to review the decision of the Appellate Court of Illinois in upholding the order of the Illinois Department of Insurance applying the Illinois Voluntary Health Services Plans Act to petitioner.

OPINIONS BELOW

The opinion of the Illinois Appellate Court (App. A) is reported at 103 Ill. App. 3d 920, 431 N.E.2d 1306 (1982). The order denying leave to appeal to the Supreme Court of Illinois (App. B) is not reported.

JURISDICTION

The decision of the Illinois Appellate Court (App. A) was entered on January 12, 1982. The decision of the Supreme Court of Illinois denying leave to appeal (App. B) was entered on May 28, 1982. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(3).

STATUTES INVOLVED

The applicable constitutional and statutory provisions are reproduced in Appendix I.

STATEMENT

This controversy arises out of the services of Consultants and Administrators, Inc. ("C & A") which administers dental and optometric services on behalf of The Chicago Newspaper Publishers Association-Drivers Union Hospital and Medical-Surgical Trust ("the Trust"). The Trust was established by agreement between the Chicago Tribune Company, Field Enterprises, Inc., Newspaper Division ("the employers") and the Newspaper, Magazine, Periodical, Salesmen, Drivers, Chauffeurs, Division Men, District Managers, Checkers, Vendors, and Handlers Union, Local 706, International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, and six individual trustees. (R. 189-214.)[1] The terms of the

[1] Record references will be indicated as follows: "R. ..."

Trust were arrived at by collective bargaining and require the employers to contribute to a fund which is used to provide certain medical benefits including dental and optical care benefits. (R. 189, 197.) The Appellate Court recognized and the Illinois Department of Insurance ("the Department") conceded that the Trust is an employee welfare benefit plan, as defined in § 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 ("ERISA"). (App. A, 2a.)

In 1976, C & A entered into a contract with the Trust which provided, *inter alia*, as follows:

> C & A hereby agrees to provide under the terms and conditions hereinafter set forth facilities for a dental care program and an optometric and vision care program, which shall include such dental care and optometric and vision care of Participants and Dependents as set forth herein.

(App. G, 24a; R. 215, ¶ 3.) Under the contract, C & A is designated a "named fiduciary" of the Trust with respect to these services. (App. G, 29a; R. 219, ¶ 19.)

The trustees of the Trust continue to have control over the manner in which C & A is to assist in providing services. (App. G, 24a-29a; R. 215-220.) The trustees have a right to determine the hours during which services are provided (App. G, 24a; R. 216, ¶ 4), to determine the order and nature of the priority among the types of services to be rendered (App. G, 25a; R. 216, ¶ 8), and to inspect both the facility and the work to determine the quality of performance (App. G, 25a-26a; R. 212, ¶¶ 9, 10). The contract also specifies that C & A must implement the trustees' recommendations regarding services or they may be terminated within 30 days. (App. G, 25a-26a; R. 217, ¶¶ 9-11.) C & A is paid $16.25 per month for each

qualified participant in the dental and vision plan. (App. G, 28a; R. 218, ¶ 17.) Teh key element of the contract is the establishment of a separate facility where employees who are qualified for benefits can go to receive dental care and optometric and vision care. (App. G, 24a; R. 216, ¶ 4.)

The Illinois Department of Insurance Proceedings.

In 1979, the contract between the Trust and C & A was about to be considered for renewal. (R. 57-59.) Respondent Illinois Vision Services Plan, a business which provides vision care service to subscribers and which is incorporated under the Illinois Vision Service Plan Act, Ill. Rev. Stat. ch. 32, §§ 651 et seq., desired to bid on a new agreement with the Trust. In February of 1979, Illinois Vision Services Plan requested that the Director of the Department investigate C & A. (R. 57-59.)

In July 1979, the Department of Insurance informed C & A that C & A's activities on behalf of the Trust violated the Illinois Vision Service Plan Act and the Illinois Dental Service Plan Act. (Ill. Rev. Stat. ch. 32, §§ 690.1 et seq.) (R. 226.) Following this notification, a hearing officer was appointed and the Department notified C & A of a hearing. (R. 45-49.)

C & A filed a motion to dismiss the proceeding, asserting that the Department had no jurisdiction over C & A because C & A was acting on behalf of an employee benefit plan, and, hence, the preemption provisions of § 514(a) of ERISA, 29 U.S.C. § 1144(a), precluded state regulation. (App. H, 31a-32a; R. 10-11, 68-69.) The Department opposed the motion to dismiss. (R. 71-72.) The Department's hearing officer denied the motion to dismiss on October 11, 1979. (R. 73-74.)

At the subsequent regulatory hearing, one witness testified, the Assistant Deputy Director of the Department. His only testimony was that in his opinion C & A's activities fell within the terms of Illinois Voluntary Health Services Plans Act, ("the Illinois Act"), Ill. Rev. Stat. ch. 32, §§ 595 et seq. (R. 107-140.)

Stating no reasons, the hearing officer recommended dismissal of the proceeding without prejudice, for further investigation. (App. E; R. 9.) The Director of the Department rejected the hearing officer's recommendation and issued an opinion concluding that C & A had failed to obtain a charter from the Department as required by Section 8 of the Voluntary Health Services Plans Act, Ill. Rev. Stat. ch. 32, § 602. The Department ordered immediate compliance. (App. F; R. 5-8.)

Many of the requirements of the Trust's contract with C & A will be nullified if C & A is required to comply with the provisions of the Illinois Act. For example, to comply with the Illinois Act, C & A will be required to contract directly with the employees; it could not contract with the employee benefit plan's trustees. Ill. Rev. Stat. ch. 32, § 606. Despite the fact that it arranges for dental and vision care services only, it will be required to have a Board of Directors which includes 30% medical doctors. Ill. Rev. Stat. ch. 32, § 599. C & A will be required to allow the employees who are seeking vision care to elect between optometrists hired by C & A and medical doctors not under contract with C & A. If an outside medical doctor is elected, C & A will be required to reimburse that doctor. Ill. Rev. Stat. ch. 32, § 609.10.

Proceedings in the Circuit Court.

On appeal of the Department's order in the Circuit Court of Cook County, C & A again asserted that the Department was without authority to regulate C & A's activities on behalf of the Plan because of the preemption provisions of ERISA. (R. 3, ¶ (b)(1); R. 301, ¶ (1); R. 302-304; see also transcript following R. 339 at 5, 8.) The Circuit Court affirmed the decision of the Department but stayed its order for 30 days. (App. D, 11a-12a; R. 331, Order of Jan. 7, 1981.) After C & A moved for rehearing or modification of the order to include findings of fact and conclusions of law, the Circuit Court modified its opinion, adopting the Department's proposed findings of fact and conclusions of law. (App. C, 10a; R. 337, Order of Jan. 30, 1981.) None of the findings or conclusions related to C & A's claim that ERISA preempted the Illinois law.

The Appellate Court Ruling.

C & A appealed the decision of the Circuit Court to the Appellate Court of Illinois, First District. C & A again argued that it was exempt from Illinois regulation by reason of the preemption provisions of ERISA. The Appellate Court affirmed the decision of the Circuit Court. It ruled only that the statutory terms of the Illinois Health Services Plans Act covered C & A's activities. Although the Court specifically ruled that the Trust was an employee benefit plan (App. A, 2a), it did not reach the issue of ERISA preemption. The Appellate Court stated that it would not "establish new Illinois precedent on a question of weighty significance" on the basis of the briefs before it. (App. A, 5a-6a.) Leave to appeal the Appellate Court's decision to the Supreme Court of Illinois was denied by order dated May 28, 1982. (App. B, 9a.)

REASONS FOR GRANTING THE WRIT

The central purpose of ERISA is to provide for all employee benefit plans a uniform system of federal regulation free from state interference. That uniformity is threatened by the regulation which the State of Illinois is attempting to impose over the manner in which C & A as an agent for a plan may administer collectively bargained for dental and vision care services.

The scope of the preemption provision of ERISA and the latitude which remains to the states to regulate the conduct of agents and fiduciaries of employee benefit plans are matters of national importance which require this Court's clarification.

The decision of the Appellate Court of Illinois failed to address the petitioner's repeated claims of ERISA preemption. The decision below will seriously undermine the statutory intent, confirmed by *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), to create broad and exclusive federal governance of employee benefit plans.

Moreover, to the extent the order turned on a legal determination that C & A was engaged in the business of insurance and therefore excluded from the preemption provision of ERISA, that decision is in conflict with the recent decisions of this Court in *Union Labor Life Insurance Company* v. *Pireno*, ... U.S. ....., 50 U.S.L.W. 4911 (June 28, 1982), and *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979), which narrowly construe the definition of the "business of insurance" contained in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15. Under these cases, administration of dental and vision care services and facilities does not fall within

the "business of insurance." Uniform application of the federal laws requires that the definition of the "business of insurance" contained in ERISA be identical to the definition of the "business of insurance" in the McCarran-Ferguson Act as recently clarified in *Pireno* and *Royal Drug*.

1. The Decision of the Illinois Appellate Court Is Inconsistent With Prior Decisions of This Court and the Lower Federal Courts Giving Broad Scope to the ERISA Preemption Provisions.

To insure uniform development and application of the regulatory scheme, § 514 of ERISA (29 U.S.C. § 1144) provides that all state laws which "relate to an employee benefit plan" shall be preempted.[2]

C & A is both a named fiduciary and an employer as defined in ERISA.[3] Its conduct in both capacities is specifically governed by ERISA. ERISA establishes standards of conduct, responsibility and obligations for employers and fiduciaries of employee benefit plans. Congress unequivocally expressed its intent to preclude state regulation of those governed by the Act.

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[2] Section 514 of ERISA reads in part:

> Except as provided in subsection (b) of this Section, the provisions of this title and title IV shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b).

[3] Section 3(5) of ERISA (29 U.S.C. § 1002(5)) defines an "employer" to mean "any person acting directly as an employer or indirectly in the interest of an employer in relation to an employee benefit plan."

Moreover, ERISA preempts not only state laws inconsistent with its provisions, or laws which seek to regulate the areas comprehensively occupied by ERISA, but also any law which relates to an employee benefit plan. Congress repeatedly rebuffed attempts to narrow the preemption provision.

The Conference Committee and Congress as a whole rejected proposals to preempt only duplicative or inconsistent state statutes in favor of preemption of the entire field of employee benefit plan regulation.[4] For example, Senator Jacob Javits, the ranking minority member of the committee which initiated the first ERISA bill, arguing against a narrow preemption provision, said:

> [T]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs.

120 Cong. Rec. 29942 (1974). *See also* statement of Senator Harrison Williams, 120 Cong. Rec. 29933 (1974) (the preemption provision was intended to apply in the broadest sense with only the exceptions specified in the Act).

This Court, as well as the lower federal courts, has ruled that the broad scope of ERISA's preemption provision requires that, when a state statute is challenged, the court must look beyond the stated purpose of the state regulation, to determine whether it has any direct or indirect impact on an employee benefit plan. In *Alessi* v.

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[4] The House version of H.R. 2 enacted in February, 1974 had a limited preemption provision. 120 Cong. Rec. 4742 (1974). A limited preemption provision was also found in the Senate version of H.R. 2, passed on March 4, 1974. 120 Cong. Rec. 5002 (1974).

Raybestos-Manhattan, Inc., 451 U.S. 504 (1981), this Court held that, as a result of ERISA's preemption provision, New Jersey could not prohibit a pension plan from reducing benefits based on a beneficiary's receipt of workers' compensation:

> ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern. . . . ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the preemption provision.

451 U.S. at 525.

In *Stone & Webster Engineering Corp.* v. *Ilsley*, 518 F. Supp. 1297 (D. Conn. 1981), the district court applied the *Alessi* decision and invalidated a state statute which required an extension of health care benefits for a prescribed period following an individual's employment. An analogous provision can be found in the Illinois Act which requires that employees be given conversion privileges permitting individual participation in the health plan when employment is terminated. Ill. Rev. Stat. ch. 32, § 609.5.

In *Standard Oil Co. of California* v. *Agsalud*, 442 F. Supp. 695 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), recently affirmed by this Court, ... U.S. ....., 102 S. Ct. 79 (1981), the district court invalidated a statute which required employers to maintain health care plans meeting state prescribed standards. The attempted regulation in *Standard Oil Co.* was very close to the attempted regulation here. C & A is an employer as defined by ERISA itself and is a "named fiduciary" of an employee benefit plan. The Department is attempting to require both a method of operation and provision of specific benefits by C & A. Illinois' attempted regulation has a direct impact on an employee benefit plan.

In the seminal decision in *Hewlett-Packard Co.* v. *Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978), a California statute which sought to regulate "health care service plans" was held to be preempted as applied to employee benefit plans. The preempted statute defined a "health care service plan" as "any person who undertakes to arrange for the provision of health care services . . . to subscribers or enrollees . . . in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees . . . ." *Id.* at 1296 (citing Cal. [Health & Safety] Code § 1345(f)). One of the options afforded by the benefit fund in *Hewlett-Packard Co.* was participation in a prepaid health and dental care plan. The court concluded that it was "indisputable" that ERISA intended to supersede the state regulation.[5]

The states cannot regulate the administration of collectively bargained for dental and vision care facilities and services on behalf of an employee benefit plan without running afoul of the language and intent of ERISA's broad preemption provision, as demonstrated by the consistent rulings of this Court and the lower federal courts. The Supremacy Clause of the Constitution, U.S. Const. art. VI, cl. 2, establishes the authority of Congress to displace state control of this entire field. *Florida Lime & Avocado Growers, Inc.* v. *Paul*, 373 U.S. 132, 142-43 (1963).

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[5] Similarly, in *St. Paul Electrical Workers Welfare Fund* v. *Markman*, 490 F. Supp. 931 (D.Minn. 1980), Minnesota tried to require that specific coverage be provided under health care plans and that the plans meet reporting requirements. The district court ruled the state law attempting to regulate employers was preempted. In *National Carriers' Conference Committee* v. *Heffernan*, 454 F Supp. 914 (D.Conn. 1978), a statute which imposed a tax on an administrator of a plan, like C & A, was held to be preempted.

That is exactly what Congress undertook to accomplish by the broad preemption provision of ERISA.

Uniform application of the Act requires that this Court establish that ERISA preempts the Illinois Voluntary Health Services Plans Act "as it relates" to C & A's administration of an employee benefit plan.

2. C & A Is Not Engaged in the Business of Insurance, As Defined in ERISA and in the McCarran-Ferguson Act.

The Department placed heavy emphasis below upon the fact that C & A receives a monthly payment from the Trust based on the number of employees who are qualified to receive benefits. The Department previously asserted that the fact of these payments was evidence that C & A was in the business of insurance and therefore excluded from ERISA's preemption provision. (Brief of Respondent Department in the Appellate Court of Illinois, at 11.) But C & A serves as agent and fiduciary of the Trust, not as an insurer of dental and optical services. If the Trust had hired dental and optical personnel and provided a facility for their work, it is incontestable that the State of Illinois would be barred from regulating the services by the preemption provision of ERISA. The fact that C & A, as an agent of the Trust, provides the facility and administers the professional services is not a basis for treating the situation differently. The administration of services collectively bargained for is not the provision of insurance.

Section 514(2)(A) of ERISA specifies that the Act does not "exempt or relieve any person from any law of

any State which regulates insurance . . . ."[6] However, this provision does not permit Illinois to "deem" C & A an insurer.[7] C & A must actually be engaged in the business of insurance for the State to have the right to regulate its activities on behalf of an employee benefit plan.

The national policy of according primacy to state regulation of insurance was originally codified by the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15. The McCarran-Ferguson Act allows the states to "regulat[e] the business of insurance," *id.*, § 1012(b). This language is very similar to ERISA's exemption from preemtion of "law[s] . . . which regulate insurance" and the "deemer" provision which prohibits defining Plan activities as "the business of insurance." ERISA's exemption for the business of insurance is also premised on the same policy of deferring to state regulation in this field. Because the two statutes reflect the same basic policy, they are *in pari materia* and should be construed consistently. This Court has twice recently considered the scope of the McCarran-Ferguson Act language and has defined narrowly the "business of insurance" in a way that demonstrates that C & A should not be subjected to state regulation under the insurance exception to ERISA preemption.

In *Union Labor Life Insurance Co.* v. *Pireno*, ... U.S. ....., 50 U.S.L.W. 4911 (June 28, 1982), this Court concluded that the actions of a peer review committee deter-

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[6] § 514(2)(A) of ERISA provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities."

[7] § 514(2)(B) of ERISA provides that no employee benefit plan or any trust established under such plan "shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance companies, insurance contracts . . . ."

mining whether chiropractors' charges under an insurance policy were "reasonable" and "necessary" fell outside the McCarran-Ferguson Act definition of the "business of insurance."

The *Pireno* ruling reflected the fact that the use of the peer review committee plays no part in the transfer of risk characteristic of insurance. *Id.* at ....., 50 U.S.L.W. at 4914. C & A's primary function is to administer the provision of dental and vision care services and facilities on behalf of an employee benefit plan. None of the administrative services it provides pertain in any way to any insurance industry practice. On the contrary, the fact that C & A assures the provision of facilities and services is a clear distinction from the reimbursement obligations normally undertaken by an insurer. The only risk spreading is the per capita monthly charge fixed in advance. This alone cannot render C & A an insurer, since any fixed contract price for services or goods acts to shift the risk of an increase in the cost of services or goods from the purchaser to the seller.

The control of prices for benefits was rejected as an activity falling within the parameters of the business of insurance in *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979). This Court found an agreement between an insurance company and pharmacies regarding the manner and size of payment for drugs under insurance policies to be outside "the business of insurance."

C & A's contractual obligations in this case fall more clearly outside the business of insurance than the practices this Court found to be beyond state regulation in *Royal Drug* and *Pireno*. Rental of facilities and negotiation of salaries by C & A are more peripheral to "the

business of insurance" than were the determination of eligibility for insurance reimbursement in *Pireno* or the payment for drugs under insurance policies in *Royal Drug*. C & A's administration of dental and health care facilities and services are not the business of insurance as defined by these cases and therefore there is no applicable exception to the preemption provision of ERISA.

The uniform application of ERISA and the uniform definition of the states' authority to regulate insurance is jeopardized by the erroneous ruling of the Illinois Appellate Court.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A

Second Division
January 12, 1982

No. 81-283

CONSULTANTS & ADMINISTRATORS, INC., an Illinois Corporation, Plaintiff-Appellant, vs. DEPARTMENT OF INSURANCE OF THE STATE OF ILLINOIS, PHILLIP R. O'CONNOR, its Director and ILLINOIS VISION SERVICES PLAN, Intervenor, Defendants-Appellees.	)	Appeal from the Circuit Court of Cook County Honorable Arthur L. Dunne, Judge Presiding

JUSTICE DOWNING delivered the opinion of the court:

Plaintiff Consultants & Administrators, Inc. (C&A) appeals from the decision of the circuit court of Cook County which upheld an administrative order entered by defendant Illinois Department of Insurance (DI). DI had directed C&A to comply with the provisions of the Voluntary Health Services Plans Act (the Health Act) (Ill. Rev. Stat. 1979, ch. 32, par. 595 *et seq.*) or show that it was exempt therefrom.

C&A argues that (1) DI lacks jurisdiction over it, having been preempted by the federal Employee Retirement Income Security Act of 1974 (ERISA); (2) the Health Act is not mandatory, but rather is permissive in nature; (3) the Health Act violates "the constitutional and civil rights" of C&A; (4) the circuit court violated C&A's procedural due process rights; and (5) DI is "perpetuating an unconstitutional monopoly" in violation of federal anti-trust law.

In 1966, the Chicago Newspaper Publishers Association and a division of the Teamsters Union agreed to create a trust entity (the Trust) for the benefit of the employees of Chicago's major daily newspapers. The trust agreement was amended in March 1976 to conform to the provisions of ERISA (29 U.S.C. §1001 *et seq.* (1976)).[1] On March 15, 1976, the Trust entered into a contract with C&A. Under that contract, C&A was to provide facilities for a dental care program and an optometric/vision care program for beneficiaries of the Trust, and was to contract with professional and technical personnel to conduct the programs. The Trust was obligated to pay C&A $16.25 per month for each participant-beneficiary enrolled in the programs.

On February 1, 1979, defendant Illinois Vision Services Plan (IVSP), a business entity incorporated under the Illinois Vision Service Plan Act (the Vision Act) (Ill. Rev. Stat. 1979, ch. 32, par. 651 *et seq.*), complained to DI that it had encountered competition from C&A, which firm, IVSP believed, had not been incorporated under that statute. IVSP requested that DI conduct an investigation of C&A's activities to determine its compliance with Illinois

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[1] The Attorney General, representing DI, informs us that the Trust itself is an "employee welfare benefit plan" under ERISA. That statute defines such a plan as:

> "[A]ny plan, fund, or program which * * * is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such a plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical * * * benefits * * *." (29 U.S.C. §1002(1) (1976).)

We accept this representation as being correct. See *e.g., Russo* v. *Boland* (1st Dist. January 8, 1982, Docket No. 80-2786), ____ Ill. App. 3d ____, ____ N.E.2d ____ (slip op. at 7).

law. DI proceeded with the requested investigation and eventually informed C&A that it believed the latter was operating in violation of both the Vision Act and the Illinois Dental Service Plan Act (the Dental Act) (Ill. Rev. Stat. 1979, ch. 32, par. 690.1 *et seq.*). DI suggested that C&A file an application for certification under the Health Act. C&A responded that it would seek a declaratory judgment in court on the matter (which action C&A apparently never pursued). In the face of C&A's intractability, DI initiated formal administrative proceedings to determine whether C&A was indeed operating in violation of the Health Act by providing dental and optical services without procuring a charter under that statute. Ill. Rev. Stat. 1979, ch. 32, par. 602.

On December 14, 1979, a hearing was held before an appointed hearing officer.[2] At that hearing, a single witness appeared, having been called by DI. Essentially, the witness, Ronald Chew, assistant deputy director in the Health Delivery Section of DI, stated that he believed C&A was operating a voluntary health services plan in violation of the provisions of the Health Act. C&A did not attempt to rebut this conclusion, instead asserting among other things that the Health Act was preempted by ERISA, was unconstitutional, and was not intended to cover the operation of a private corporation.

The hearing officer recommended that DI terminate the proceeding without prejudice. The director of DI declined to accept this recommendation. Instead, he issued a lengthy administrative decision finding C&A to be operating a voluntary health services plan without incorporating under the Health Act, in violation of that statute. The

[2] IVSP was allowed to intervene in this and subsequent proceedings.

director ordered C&A to comply therewith. C&A responded by seeking judicial review of this administrative determination. After hearing the parties' arguments and examining their briefs, the circuit court affirmed the administrative decision in its entirety.

I.

C&A argues that ERISA preempts the Health Act and that DI thus lacked jurisdiction to proceed against it, relying on the following provisions of ERISA:

> "(a) Except as provided in subsection (b) of this section, the provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan * * *.
>
> * * *
>
> (b)(2)(A) Except as provided in subparagraph (B), nothing in [ERISA] shall be construed to exempt or relieve any person from any law of any State which regulates insurance * * *.
>
> (B) Neither an employee benefit plan * * * nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer * * * or to be engaged in the business of insurance * * * for the purposes of any law of any State purporting to regulate insurance companies * * *."

29 U.S.C. §1144 (1976).

Initially, we note that C&A has not adequately contested on this appeal the factual finding of DI, which was affirmed by the circuit court, that C&A is operating a "voluntary health services plan" as defined in the Health Act,[3] and that C&A has not incorporated under the pro-

[3] The Health Act defines such a plan as "a plan or system under which medical, hospital, dental, nursing and relating health services may be rendered to a subscriber or beneficiary, at the expense of a health services plan corporation." Ill. Rev. Stat. 1979, ch. 32 par. 596(b).

visions of the Health Act. (Ill. Rev. Stat. 1979, ch. 32, par. 597.) Our resolution of this appeal thus proceeds from the premise that these factual determinations are correct. Consequently, we note that under these circumstances, C&A is subject to the provisions of the Health Act unless it is able to succeed on the merits of the ERISA-preemption argument or on its other claims.[4]

Turning to the merits of C&A's argument, we are faced with an insurmountable obstacle to our resolution thereof. C&A has asked us to establish new Illinois precedent on a question of weighty significance, but has cited to us only two tangentially related federal decisions and a segment of a California statute which we find of no relevance.[5] C&A's brief presents no argument demonstrating the relationship of the cases and the California statute to the present circumstances; its presentation at oral argument failed to clarify the matter. We note that the briefs of the Attorney General (representing DI) and IVSP attempted to address the substance of the issue in a coherent manner despite C&A's failings. Nonetheless, we do not feel that the law on the question nor the theorizations of either side thereupon have been adequately presented so as to enable this court to establish enlightened precedent

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[4] We do not find any of the listed exceptions to the applicability of the Health Act, found in section 3, to be relevant to this case. See Ill. Rev. Stat. 1979, ch. 32, par. 597.

[5] C&A cites this court to *Delta Air Lines, Inc.* v. *Kramarsky* (2nd Cir. 1981), 650 F.2d 1287; *Hewlett-Packard Co.* v. *Barnes* (N.D. Cal. 1977), 425 F.Supp. 1294, *aff'd* (9th Cir. 1978), 571 F.2d 502, *cert. denied*, 439 U.S. 831; and CAL. GOV'T CODE §12530 (Deering 1981 Supp.), *repealed* July 1, 1976, Stats. 1975, ch. 941, §1. We note again that C&A provided this court with *no* discussion of how these cited authorities are related to the circumstances of this case.

in this complex field. This court will not research and argue a case for an appellant. (See *Thanopoulos* v. *Pickens* (1st Dist. 1980), 87 Ill. App. 3d 906, 909, 409 N.E.2d 477; *Fogel* v. *Hodes* (1st Dist. 1979), 68 Ill. App. 3d 594, 600, 386 N.E.2d 389; *47th & State Currency Exchange, Inc.* v. *B. Coleman Corp.* (1st Dist. 1977), 56 Ill. App. 3d 229, 231-33, 371 N.E.2d 294, *appeal denied* (1978), 71 Ill. 2d 598.) This rule is especially applicable where, as here, the court's decision has such potentially significant ramifications. In light of the inadequacies of C&A's presentation of the ERISA preemption issue, we decline to reach its merits.[6] The remainder of this opinion therefore proceeds from the presumption that, despite ERISA, the Health Act is indeed applicable to C&A (barring its inapplicability based upon C&A's other arguments).

II.

C&A claims that the Health Act is "voluntary and not mandatory" and thus does not cover the type of arrangement involved in this case.

C&A presents us with no relevant, authoritative support for its contention. This court has previously noted the underlying concerns of a statute similar to the Health Act: the Vision Act. (Ill. Rev. Stat. 1979, ch. 32, par. 651 *et seq.*) We noted that the Vision Act involves two major concerns: that corporations providing vision services have sufficient monetary reserves to insure the performance of

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[6] As the remainder of our opinion makes clear, C&A's briefs in this case failed to even minimally comply with the terms of Supreme Court Rule 341 regarding the content of briefs. (73 Ill. 2d R. 341.) We suggest that appellate counsel make use of the directive provisions of that rule.

their contractual obligations, and that beneficiaries of such plans have the opportunity to choose from a significant plurality of available practitioners in using the vision services provided. (*National Consolidated Industries, Ltd.* v. *Department of Insurance* (1st Dist. 1979), 73 Ill. App. 3d 816, 820-21, 392 N.E.2d 295.) We believe these concerns are equally applicable to health services rendered by a health services plan corporation. Clearly, achievement of these considerations would be severely undermined were the Health Act read as a permissive, rather than mandatory, statute. Consequently, we are unconvinced by C&A's unsupported claim to that effect. The Health Act envisions mandatory compliance by all voluntary health services plans, including C&A.

III.

C&A raises constitutional issues in regard to the outcome below.

A.

C&A claims that the Health Act is unconstitutional. In support of this argument, C&A reprints a large segment of the supreme court's opinion in *Scully* v. *Hallihan* (1936), 365 Ill. 185, 6 N.E.2d 176, and adds a one-sentence "paraphrasing" of the rule of that case applied to the facts of this case. General allegations of constitutional violations which do not specify the manner in which the asserted constitutional rights are infringed do not adequately raise constitutional claims. (*Redmond* v. *Novak* (1981), 86 Ill. 2d 374, 378, 427 N.E.2d 53.) We therefore will not address this part of C&A's constitutional claim.

B.

C&A argues that it was denied procedural due process in the circuit court proceeding, citing *Drezner* v. *Civil Service Commission of the State of Illinois* (1947), 398 Ill. 219, 231, 75 N.E.2d 303. We have reviewed the record of

proceedings from the circuit court and find no basis therein for holding that the circuit court's action violated either the rule of the *Drezner* case or any constitutional matters connected therewith.

IV.

Finally, C&A contends that DI "and other persons, corporations, and associations * * * have combined to restrain competition in the field of health service in violation of the Anti-Trust laws of the United States," citing the United States Code.

Judicial proceedings under federal anti-trust statutes (15 U.S.C. §1 *et seq.* (1976)) may only be brought in federal court; state courts lack jurisdiction to accept such causes of action.[7] (See *Blumenstock Brothers Advertising Agency* v. *Curtis Publishing Co.* (1920), 252 U.S. 436, 440, 64 L. Ed. 649, 40 S. Ct. 385; *Van Dussen-Storto Motor Inn, Inc.* v. *Rochester Telephone Corp.* (1972), 72 Misc. 2d 34, 338 N.Y.S.2d 31, 34-35, *modified on other grounds* (1973), 42 A.D.2d 400, 348 N.Y.S.2d 404, *aff'd* (1974), 34 N.Y.2d 904, 359 N.Y.S.2d 286; see generally 54 Am. Jur. 2d *Monopolies, Restraints of Trade, and Unfair Trade Practices,* §265 (1971).) Thus, C&A's claim cannot be addressed by this court.

For the foregoing reasons, we affirm the decision of the circuit court of Cook County.

Affirmed.

STAMOS, P.J., and HARTMAN, J., concur.

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[7] In order to bring a valid anti-trust claim in Illinois courts, C&A should have relied upon the Illinois Antitrust Act. Ill. Rev. Stat. 1979, ch. 38, par. 60-1 *et seq.*

APPENDIX B

ILLINOIS SUPREME COURT
H. Wayne Russell, Clerk
Supreme Court Building
Springfield, Ill. 62706
(217) 782-2035

May 28, 1982

Mr. Thomas P. Sullivan
Attorney at Law
One IBM Plaza
Chicago, IL 60611

No. 56316—Consultants and Administrators, Inc., an Illinois corporation, petitioner, vs. Department of Insurance of the State of Illinois, et al., etc., et al., respondents. Leave to appeal, Appellate Court, First District.

The Supreme Court today DENIED the Petition for leave to appeal in the above entitled cause.

Very truly yours,

/s/ H. Wayne Russell
Clerk of the Supreme Court

APPENDIX C

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

CONSULTANTS and ADMINISTRATORS,	)	
v.	)	No. 80 L 15569
DEPARTMENT OF INSURANCE	)	

ORDER

THIS CAUSE COMING on to be heard on motion of plaintiff for rehearing or in the alternative for findings of fact and conclusions of law, the court having heard argument of counsel and being fully advised in the premises;

IT IS HEREBY ORDERED:

That the Court adopt the findings of fact and conclusions of law of the Department of Insurance as its findings of fact and conclusions of law;

It Is Further Ordered that this Court's Order of January 7, 1981 is reaffirmed.

DATED: January 30, 1981
ENTER: */s/ Arthur L. Dunne*
Judge

Martin, Craig, Chester
& Sonnenschein
Attorney for Illinois Vision
Service Plan
115 S. LaSalle Street
Chicago, Illinois
(312) 368-9700

APPENDIX D

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

COUNTY DEPARTMENT, LAW DIVISION

CONSULTANTS & ADMINISTRATORS, INC., an Illinois Corporation, Plaintiff	)	
v.	)	No. 80 L 15569
DEPARTMENT OF INSURANCE OF THE STATE OF ILLINOIS; PHILIP R. O'CONNOR, Its Director; and ILLINOIS VISION SERVICES PLAN, Intervenor, Defendants.	)	

ORDER

This cause coming on to be heard, as a set matter, on the Complaint For Administrative Review, filed herein by Plaintiff, Consultants & Administrators, Inc., the Court having considered the brief and memorandum filed herein and the oral argument of the parties through their respective counsel, and the Court being otherwise fully advised in the premises;

THE COURT HEREBY FINDS THAT THE FINAL ADMINISTRATIVE DECISION OF THE Director Of The Department Of Insurance is supported by the evidence in the record and is in accordance with the law in all respects;

IT IS THEREFORE HEREBY ORDERED that the final administrative decision of the Director of the Department of Insurance be and hereby is affirmed in its entirety.

IT IS FURTHER ORDERED that the order be stayed for 30 days from the date hereof.

Dated: January 7, 1981

Enter: /s/ *Arthur L. Dumne*
Judge

Martin, Craig, Chester
& Sonnenschein
Attorney for Illinois Vision
Service Plan
115 S. LaSalle Street
Chicago, Illinois 60603
(312) 368-9700

APPENDIX E

STATE OF ILLINOIS
Department Of Insurance

DEPARTMENT OF INSURANCE
OF THE STATE OF ILLINOIS,
COMPLAINANT,

VS. HEARING NO. 1856

CONSULTANTS AND ADMINISTRATORS, INC.
220 SOUTH ASHLAND
CHICAGO, ILLINOIS 60607
RESPONDENT.

FINDINGS AND RECOMMENDATIONS OF THE HEARING OFFICER

This matter having come on for hearing in Springfield, Illinois on December 14, 1979, upon the filing of a Notice of Hearing by Complainant, Department of Insurance, State of Illinois, by its Acting Director, Philip R. O'Connor, the undersigned Judy B. Kjellander, having acted as Hearing Officer pursuant to designation and appointment of the Director of Insurance, the parties and Intervenor, Illinois Vision Services Plan, having appeared in open hearing and having filed substantive briefs with the Hearing Officer, the Hearing Officer having considered the testimony, evidence, exhibits, and memoranda filed herein, having further considered the available provisions of the Voluntary Health Services Plan Act and other related Acts, and being fully advised in the premises, does find and recommend as follows:

FINDINGS

1. That the Department of Insurance has jurisdiction in this matter pursuant to Section 10 of the Voluntary Health Services Plan Act (Ill. Rev. Stat., 1977, Ch. 32 § 604), and Sections 401-403 of the Illinois Insurance Code (Ill. Rev. Stat., 1977, Ch. 73, §§ 1013-1015.

2. That Judy B. Kjellander is the validly designated and appointed Hearing Officer in this matter.

3. That Illinois Vision Services Plan has validly intervened in this matter pursuant to Department of Insurance Rule 24.02.

RECOMMENDATIONS

IT IS RECOMMENDED based upon the evidence admitted at the Hearing, that the Acting Director of the Department of Insurance, State of Illinois, dismiss this proceeding without prejudice to Complainant, for further investigation and regulatory action, if appropriate.

Respectfully submitted,

/s/ Judy B. Kjellander
Judy B. Kjellander

APPENDIX F

STATE OF ILLINOIS
Department Of Insurance

DEPARTMENT OF INSURANCE
OF THE STATE OF ILLINOIS,
COMPLAINANT,

VS. HEARING NO. 1856

CONSULTANTS AND ADMINISTRATORS, INC.
220 SOUTH ASHLAND AVENUE
CHICAGO, ILLINOIS 60607,
RESPONDENT.

ORDER

The undersigned, Philip R. O'Connor, Director of the Department of Insurance of the State of Illinois, hereby certifies that he has read the Record in this cause, and that he has carefully considered the Record and is fully advised in the premises. This Order is entered under the authority granted to the Director of Insurance by the applicable sections of the Illinois Insurance Code and the Voluntary Health Services Plans Act.

FINDINGS OF FACT

After examination of the Record in this matter, I hereby make the following Findings of Fact:

1. That a Notice of Hearing and Appearance of the Department's attorney was mailed to Consultants and Administrators, Inc. (Respondent) on September 5, 1979, setting this matter for Hearing on September 18, 1979 at 9:30 A.M. (Hearing Officer Group Exhibit #1B, #1C)

2. That Judy B. Kjellander was appointed Hearing Officer on September 18, 1979. (Hearing Officer Group Exhibit #1A)

3. That the Notice of Hearing alleges that Respondent is providing dental and optical services to subscribers or beneficiaries at the expense of the Respondent without first procuring a charter as required by Section 8 of the Voluntary Health Services Plans Act (Ill. Rev. Stat. 1977, Ch. 32, par. 602). (Hearing Officer Group Exhibit #1B)

4. That the date of this Hearing was continued on Motion of the Respondent, and agreed to by the Complainant, to October 18, 1979. (Hearing Officer Group Exhibit #1F)

5. That Illinois Vision Service Plan (Intervenor) petitioned to intervene in this matter on September 25, 1979, alleging that it may be adversely affected by a final order arising from this proceeding, and that Intervenor's circumstances have questions of law and fact in common with those present in this matter. (Hearing Officer Group Exhibit #1I)

6. That the Complainant and Respondent filed written objections to Intervenor's Motion to Intervene. (Hearing Officer Group Exhibit #1K and 1M)

7. That Intervenor's Motion for Intervention was denied by the Hearing Officer on October 9, 1979. (Hearing Officer Group Exhibit #1N)

8. That Respondent filed a Motion to Dismiss the complaint on October 4, 1979. (Hearing Officer Group Exhibit #1P)

9. That the Department filed written objection to Respondent's Motion to Dismiss on October 5, 1979. (Hearing Officer Group Exhibit #1Q)

10. That the Respondent's Motion to Dismiss was denied by the Hearing Officer on October 11, 1979. (Hearing Officer Group Exhibit #1R)

11. That a Hearing was held in this matter on October 18, 1979.

12. That at said Hearing, Intervenor submitted a written Motion for Rehearing and Reconsideration of the Hearing Officer's October 9, 1979 Order denying intervention. (Hearing Officer Group Exhibit #2B, Transcript of October 18, 1979, p. 7)

13. That the Hearing Officer ordered that all written responses to Intervenor's Motion for Rehearing and Reconsideration be filed with the Hearing Officer by October 28, 1979. (Transcript of October 18, 1979, p. 10)

14. That at said Hearing this cause was ordered continued generally upon motion of the Complainant and agreed to by Respondent. (Transcript of October 18, 1979, p. 6)

15. That the Respondent filed written objections to Intervenor's Motion for Rehearing and Reconsideration on October 26, 1979 reciting its previous objections to intervention dated October 2, 1979. (Hearing Officer Group Exhibit #2C and #1P)

16. That the Complainant filed written objections to Intervenor's Motion for Rehearing and Reconsideration on October 29, 1979, reciting its previous objections to intervention dated October 1, 1979. (Hearing Officer Group Exhibit #2F and #1K)

17. That the Hearing Officer, in an Order dated October 30, 1979, vacated her Order of October 9, 1979 and allowed Intervenor to intervene in this cause. (Hearing Officer Group Exhibit #2D and #1N)

18. That the Complainant, on November 1, 1979, filed a written Request for Grounds and Reconsideration of Hearing Officer's Order of October 30, 1979 and Continuing Objection to the Intervention of Intervenor. (Hearing Officer Group Exhibit #2H)

19. That this cause was continued to December 3, 1979 by Hearing Officer's Order dated November 6, 1979. (Hearing Officer Group Exhibit #2J)

20. That Intervenor filed a written response to the Complainant's Request for Reconsideration on November 5, 1979. (Hearing Officer Group Exhibit #2L)

21. That on November 6, 1979 the Respondent filed written objections to the Hearing Officer's Order of October 30, 1979, in which Respondent agreed with the Complainant's Request for Reconsideration and the grounds stated therein. (Hearing Officer Group Exhibit #2M, #2D, and #2H)

22. That Complainant filed a written Request for Permission to Reply to Intervenor's response to Complainant's Request for Reconsideration on November 7, 1979. (Hearing Officer Group Exhibit #2N)

23. That the Hearing Officer denied Complainant's Request for Permission to Reply in an Order dated November 28, 1979. (Hearing Officer Group Exhibit #2P)

24. That this cause was continued until December 14, 1979 on Respondent's motion and upon agreement of Complainant and Intervenor. (Hearing Officer Group Exhibit #2R and #2S)

25. That Respondent filed a Motion to Disqualify the Hearing Officer on November 29, 1979. (Hearing Officer Group Exhibit #2T)

26. That then Acting Director of Insurance, Philip R. O'Connor, in a letter dated December 12, 1979 to George J. Haddad, Attorney for Respondent, denied Respondent's Motion to Disqualify the Hearing Officer. (Hearing Officer Exhibit #2U)

27. That Hearing No. 1856 was convened on December 14, 1979 in the Office of the Department of Insurance, Springfield, Illinois.

28. That Respondent made an oral motion to set aside the Hearing Officer's Order of October 11, 1979 which denied Respondent's October 4, 1979 Motion to Dismiss. (Transcript of December 14, 1979, pp. 8-19).

29. That Respondent's motion to set aside the Hearing Officer's Order of October 11, 1979 was denied based on Rule 24.02, Section H of Section 10 of the Illinois Insurance Department Rules and Regulations. (R. 19-20)

30. That Respondent is a corporation organized under the laws of the State of Illinois. (Department Exhibit #2)

31. That Respondent entered into a contract with Chicago Newspaper Publishers Association—Drivers Union Hospital and Medical-Surgical Trust (Trust) on March 15, 1976. (Department Exhibit #2)

32. That said contract states that Respondent is to provide facilities for dental and vision care services to employees and dependents covered by the Trust. (Department's Exhibit #2 and #3, R. 30)

33. That by said contract, Respondent shall contract with duly licensed professional and technical personnel to provide all necessary and appropriate dental and vision care services listed in said contract. (Department's Exhibit #2)

34. That Respondent is to provide all dental and vision care services to participants and dependents as stated in said contract, regardless of the number of services and costs of services provided in return for the payment of $16.25 per month per participant by the Trust. (R. 33 and Department's Exhibit #2)

35. That Respondent pays the providers of services for services that are rendered to participants and dependents under said contract. (R. 51)

36. That Respondent is not chartered in Illinois as a Voluntary Service Plan Corporation. (R. 33)

CONCLUSIONS OF LAW

Based upon the above Findings of Fact, I hereby make the following Conclusions of Law:

1. That I have jurisdiction in this matter pursuant to Section 10 of the Voluntary Health Services Plans Act (Ill. Rev. Stat. 1977, Ch. 32, par. 604) and Sections 401-403 of the Illinois Insurance Code (Ill. Rev. Stat. 1977, Ch. 73, pars. 1013-1015).

2. That Judy B. Kjellander was properly appointed Hearing Officer in this cause in accordance with Section 402 of the Illinois Insurance Code (Ill. Rev. Stat. 1977, Ch. 73, par. 1014).

3. That the providing of vision care services falls within the meaning of ". . . relating health services . . ." as stated in Section 2(b) of the Voluntary Health Services Plans Act (Ill. Rev. Stat. 1977, Ch. 32, par. 596(b)).

4. That under the terms of the contract between Trust and Respondent, Respondent provides the dental and vision care services at its own expense.

5. That under the terms of said contract, Respondent has established and is operating a Voluntary Health Services Plan as defined in Section 2(b) of the Voluntary Health Services Plans Act (Ill. Rev. Stat. 1977, Ch. 32, par. 596(b)).

6. That Respondent has and is operating a Voluntary Health Services Plan without procuring a charter from the Department of Insurance as required by Section 8 of the Voluntary Health Services Plans Act (Ill. Rev. Stat. 1977, Ch. 32, par. 602).

IT IS THEREFORE ORDERED:

1. That Respondent take immediate action to comply with the requirements of the Voluntary Health Services Plans Act (Ill. Rev. Stat. 1977, Ch. 32, par. 595) or demonstrate to the Department's satisfaction that it falls within the exemptions stated in Section 3 of the Voluntary Health Services Plans Act (Ill. Rev. Stat. 1977, Ch. 32, par. 597), within thirty (30) days of the date hereof; and

2. That Respondent pay the costs of this Hearing of $197.10, to Ms. Connie Golembeck, Court Reporter, R. R. #1, Box 145, Petersburg, Illinois 62675.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed the Official Seal of the Department of Insurance in the City of Springfield, State of Illinois, this 30th day of May, A. D. 1980.

/s/ *Philip R. O'Connor*
Philip R. O'Connor
Director of Insurance

(Seal)

APPENDIX G

Chicago Newspaper Publishers
Association-Drivers Union
Hospital and Medical-
Surgical Trust
Room 346
410 North Michigan Avenue
Chicago, Illinois 60611
March 15, 1976

Consultants & Administrators, Inc.
220 South Ashland Avenue
Chicago, Illinois 60607

Gentlemen:

Consultants & Administrators, Inc., an Illinois corporation (hereinafter "C & A"), has agreed to provide certain facilities where dentists and optometrists shall provide dental and optical services for Participants (and Dependents) covered by the CNPA-Drivers Union Hospital and Medical-Surgical Trust (hereinafter the "Trust"), under the following terms and conditions:

(1) C & A has developed a program for providing facilities for dental and vision care services operated by competent dentists and optometrists, and a system for the reporting and analysis of services provided therein through a method of programming and coding of such information. C & A represents that the services to be performed by it pursuant to this agreement do not violate any laws of the State of Illinois, and do not constitute the illegal practice of medicine.

(2) The Trust is an employee welfare benefit trust established and maintained pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA") and

the laws of the State of Illinois to provide hospital and medical and similar benefits to employees covered by collective bargaining agreements entered into by and between the Employers and the Union.

(3) C & A hereby agrees to provide under the terms and conditions hereinafter set forth facilities for a dental care program and an optometric and vision care program, which shall include such dental care and optometric and vision care of Participants and Dependents as set forth herein.

(4) During the term of this agreement, C & A shall furnish and maintain a modern and adequate facility located in Cook County, and shall contract with a complement of competent, duly licensed or certified professional and technical personnel sufficient to conduct a dental care program and optometric and vision care program for all Participants and Dependents. The facility shall be open and available to Participants and Dependents at such reasonable hours as determined from time to time by the Trust and C & A.

(5) C & A shall make provision that all necessary and appropriate dental care and optometric and vision care consistent with standards of care prevailing in the profession be provided to Participants and Dependents by such certified professional and technical personnel. A list of the dental services to be provided under this agreement is attached hereto as Exhibit "A". A list of the optometric and vision care services to be provided under this agreement is attached hereto as Exhibit "B". The exhibits also list the current relative dollar values of such services, which values are only for the statistical purposes of determining the values of the services performed pursuant to this agreement.

(6) Emergency dental services shall be available on a twenty-four hour basis to Participants and Dependents, and C & A shall provide a twenty-four hour telephone answering service for the program.

(7) No services shall be furnished hereunder which are required because of an injury which arises out of or occurs in the course of any occupation or employment for wages or profit, or sickness for which the patient is entitled to benefits under any workman's compensation or occupational disease law.

(8) In the administration of this program, it is realized that the volume of patients utilizing the facility will necessitate certain streamlined administrative procedures, but the professional services shall not be subject to any different standards of professional care than apply in the individual practice of the dental and optometric professions in the area served hereunder. The parties may by mutual agreement, and from time to time, determine the order and nature of priority among various types of services to be rendered to patients under this agreement.

(9) The Trust may, at its own expense, retain qualified dentists to make periodic reviews of the dental care section of the facility supplied by C & A, and the quality of the work supplied therein, and such dentists may make recommendations for the purpose of improving the quality of such section of the facility and service, and C & A agrees to accept and implement such recommendations as hereinafter provided.

(10) The Trust may, at its own expense, retain qualified optometrists to make periodic reviews of the optometric and vision care sections of the facility supplied by C & A, and the quality of the work supplied therein, and

such optometrists may make recommendations for the purpose of improving the quality of such sections of the facility and services, and C & A agrees to accept and implement such recommendations as hereinafter provided.

(11) If the dentists and/or optometrists employed by the Trust certify in writing that services performed in certain sections of said facility are not in accordance with the professional standards of reasonable competence, skill and care prevailing among general practitioners of dentistry or optometry, as the case may be, in the Chicago area, and further certify their detailed objections thereto, and their recommendations for correcting the conditions, then the Trust shall promptly submit such findings and recommendations to C & A. If C & A fails to take action to comply with the recommendations within a period of 30 days (or such longer period as the Trustees shall authorize), the Trust shall have the right to terminate this agreement.

(12) C & A shall have and hold the Trust, the trustees of the Trust and its employees and agents, and the Employers and the Union, harmless from any and all claims of whatsoever nature, including all claims, damages, losses and expenses (including attorneys' fees) arising out of or resulting from the performance of the services rendered by any person under this agreement.

(13) C & A shall carry and maintain such liability insurance as will protect the Trust and the trustees of the Trust and the Employers and the Union, individually and collectively, and their agents and employees, against all claims, damages, losses and expenses (including attorneys' fees), referred to in paragraph (12) hereof. Such insurance shall be carried by C & A during the term of

this agreement with a company licensed to do business in the State of Illinois and with a Bests Insurance Guide rating of at least A with minimum limits of liability of:

Personal injury	$ 500,000 each person
	$1,000,000 each occurrence
Property damage	$ 500,000 per occurrence

A certificate of insurance from the insurance carrier naming the Trust and the Employers as additional insureds with clauses providing for a thirty-day prior written notice of cancellation and/or non-renewal to the Trust and the Employers shall be filed with the Trust. The liability of C & A under paragraph (12), however, shall not be limited to the limits of the insurance policies.

(14) Each dentist and optometrist performing services under the program shall be required by C & A to carry professional liability insurance with minimum limits of liability of:

$100,000 each claim
$300,000 for all claims arising in any one year

The insurance shall be with a company licensed to do business in the State of Illinois and with a rating of at least A in Bests Insurance Guide. A certificate of insurance from this carrier naming the Trust and the Employers as additional insureds with clauses providing for a thirty-day prior written notice of cancellation and/or non-renewal to the Trust and the Employers shall be filed with the Trust.

(15) C & A shall assume and bear full responsibility to see that all personnel working in the facility are, to the extent required by law, duly licensed or certificated to perform their duties in the facility. No dentist or optome-

trist or other professional may be employed in the facility except under written agreement to the extent required under a policy of professional liability insurance, nor shall any professional be employed in the facility who, for whatever reason, is not insurable under such liability insurance policy.

(16) The Trust shall promptly supply C & A with an alphabetical list of eligible Participants stating the coverage to which each such Participant is entitled and C & A may rely on the accuracy of such a list for the purposes of this agreement.

(17) The Trust shall pay to C & A for services under this agreement, on or about the fifteenth day of each month during the term hereof, commencing with the effective date of this agreement, the sum of $16.25 per month for each Participant appearing on the list so supplied by the Trust, except that if the exact number of Participants is not then available payment shall be based on a reasonable estimate of the number of Participants, and adjustment of the payment due shall be made on or about the fifteenth day of the following month. The payment of $16.25 per month for each Participant shall cover dental, vision and preventive care services as described in Exhibits "A" and "B" for each Participant and his Dependents.

(18) Experience reports shall be furnished to the Trust by C & A initially following the first three months of operation and thereafter quarterly. The content and form of such experience reports shall be in accordance with the requirements of the Trust's accountants. Such reports may be audited by the Trust's accountants, and C & A's records on which such reports are based shall be made available for such audit quarterly. Such reports shall be based on the relative values stated in Exhibits

"A" and "B". C & A shall provide the Trust with printed material describing the services available under the agreement to be distributed by the Trust to the Participants.

(19) C & A shall be the "Named Fiduciary" with respect to benefits provided hereunder, as required by ERISA.

(20) As used in this agreement, the following terms have the meanings defined, except when the context requires otherwise:

(a) "Participant" means anyone who is a participant in and entitled to benefits under the Chicago Newspaper Publishers Association-Drivers Union Hospital and Medical-Surgical Trust and whom the Trust has designated to the C & A as being eligible for services from the C & A.

(b) "Dependent" means the spouse of a Participant and any of his unmarried children between the ages of 2 weeks and 19 years (or 23 years if such child is financially dependent upon the Participant and is attending school or college on a full-time basis), and excludes a legally separated spouse, stepchild, legally adopted child or foster child unless such child is dependent upon the eligible Participant for support and maintenance and whose name has been reported to the Trust not less than thirty days prior to the date he seeks dental or vision care provided further that such dependents are not eligible as employees hereunder and are not in military service.

(c) "Employers" means Chicago Tribune Company, Field Enterprises, Inc., Newspaper Division, Publisher of the Chicago Daily News and Chicago Sun-Times.

(d) "Union" means Newspaper, Magazine, Periodical, Salesmen, Drivers, Chauffeurs, Division Men, District Managers, Checkers, Vendors and Handlers' Union, Local 706, I.B. of T., C., W. and H. of A.

(21) This agreement shall be in effect for a term of three years commencing March 15, 1976, and ending March 14, 1979, unless sooner terminated (a) pursuant to the provisions of paragraph (11), or (b) in the event the Trustees are not authorized to offer dental and optometric and vision care under the controlling collective bargaining agreement by and between the Employers and the Union.

If the foregoing is in accordance with your understanding of our agreement as outlined above, please sign and return the enclosed copy of this letter to me.

Very truly yours,

Chairman
By: /s/ *Jerome T. Hayes*
Vice-Chairman
By: /s/ *Tony Judge*

Acknowledged and accepted: Date: 3/15/76
CONSULTANTS & ADMINISTRATORS, INC.
By: /s/ *Daniel Melano*
As Its Exec. V.P.

ATTEST:
/s/ .....

APPENDIX B

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

DEPARTMENT OF INSURANCE
OF THE STATE OF ILLINOIS,
COMPLAINANT,

VS. HEARING NO. 1856

CONSULTANTS AND ADMINISTRATORS, INC.
220 SOUTH ASHLAND AVENUE
CHICAGO, ILLINOIS 60607
RESPONDENT.

MOTION TO DISMISS COMPLAINT

The above named respondent, by its undersigned attorney, moves the Department of Insurance to dismiss its Complaint, on each of the following grounds:

(1) The Department is without jurisdiction of the subject matter of the complaint. The Federal "Employee Retirement Income Security Act of 1974", Section 514, reads in part, as follows:

> (a) Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.
>
> (b) Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) (Other than a plan established primarily for the purpose of providing death benefits), nor any trust es-

tablished under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for the purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(*Hewlett-Packard Co.* v. *Barnes* D.C. Cal. 1974, 425 F.2d 502, affirmed 571 F.2d 502 (C.C.A.) Certiorari denied, 99 Supreme Court 108)

(2) The Illinois "Voluntary Health Service Plan Act violates the constitutional and civil rights of the respondent to, wit:

It deprives the respondent of due process of law and denies it the equal protection of the law under the Fourteenth Amendment to the United States Constitution, in requiring that the respondent operate as a not-for-profit corporation, but permitting insurance companies to organize for profit to sell dental care insurance.

(3) It appears from the petition filed herein by Illinois Vision Service Plan that these proceedings were instituted at its request on its complaint that the respondent was underbidding it for service contracts. It therefore appears that Illinois Vision Service Plan, The Department of Insurance, and other persons, corporations, and associations to be later identified, have combined to restrain competition in the field of health service in violation of the Anti-Trust laws of the United States (Title 15 Section 1337 of the United States Code annotated.) See also *American Medical Association* v. *United States* 317 U.S. 519-536, 87 L. Ed. 434).

(4) In the Department's letter of July 20, 1979, addressed to the undersigned as attorney for the respondent, the Department has taken the following position.

"Having reviewed the above documentation it is the opinion of the Insurance Department that C & A is operating in violation of the Vision Service Plan Act (Ill. Rev. Stat. ch. 32, par. 651 et seq.) and the Dental Service Plan Act (Ill. Rev. Stat. ch. 32, par. 690.1 et seq.)."

Therefore, a hearing would be superfluous, for the Department is presuming to pass judgment on questions of fact and law that it has already decided against the respondent.

Dated October 2, 1979.

/s/ *George J. Haddad*
George J. Haddad
Attorney for Respondent
20 North Wacker Drive
Chicago, Illinois 60606

APPENDIX I

U.S. CONST. art. VI, cl. 2:

This Constitution and the Laws of the United States which shall be made in pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any thing in the Constitution or Laws of any State to the contrary notwithstanding.

The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., provides in 29 U.S.C. § 1144:

SEC. 514. (a) Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or

banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 506 of this Act.

(4) Subsection (a) shall not apply to any generally applicable criminal law of a State.

(c) For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title.

(d) Nothing in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 111 and 507(b)) or any rule or regulation issued under any such law.

The Voluntary Health Services Plans Act, Ill. Rev. Stat. ch. 32, §§ 595 et seq., provides in relevant part:

§ 596. Definitions.

§ 2. For the purposes of this Act, the following terms have the respective meanings set forth in this section, unless different meanings are plainly indicated by the context:

(a) "Health Services Plan Corporation" means a corporation organized under the terms of this Act for the sole and specific purpose of establishing and operating a voluntary health services plan.

(b) "Voluntary health services plan" means a plan or system under which medical, hospital, dental, nursing and relating health services may be rendered to a subscriber or beneficiary, at the expense of a health services plan corporation.

§ 597. Authority to establish or operate plan—Exceptions.

§ 3. It shall be unlawful for any person, except a health services plan corporation, incorporated under this Act, to establish, maintain or operate a voluntary health services plan. This prohibition, however, shall not be construed as preventing the organization and operation of a medical service plan or a hospital service plan, incorporated respectively, under the "Medical Service Plan Act", approved July 25, 1945, as amended, or "The Non-Profit Hospital Service Plan Act", approved July 6, 1935, as amended, nor shall it be construed as preventing a person from furnishing health services to his employees or from furnishing such medical services as are required under the workers' compensation laws and related legislation, when the employees are not charged for such services; nor shall it be construed to prohibit an insurance company, or other corporation or society, which is subject to the supervision of the Director from operating in accordance with the laws governing insurance companies or such corporations or societies; nor shall it be construed to prohibit the continued operation of any medical or health service plan in existence and functioning at the effective date of this Act.

§ 599. Management of corporation—Board of trustees—Medical Director.

§ 5. The business and affairs of a health services plan corporation shall be managed by a board of trustees, which shall have the power to adopt, and to amend from time to time, by-laws governing the conduct of the corporation's business. The board of trustees shall consist of not less than seven persons, all of whom shall have the same general qualifications as the incorporators, and at least 30% of whom shall, in addition, be physicians licensed in Illinois to practice medicine in all of its branches . . . .

§ 606. Schedule of rates—Filing—Approval.

§ 12. No health services plan corporation shall enter into any contract with a subscriber until it (1) has filed with the Director a schedule of the rates to be paid by a subscriber with respect to each type of contract and (2) the Director has approved the rate for each type of contract.

§ 609.5. Conversion privilege—Group type contracts.

§ 15.5. Conversion privilege—Group type contracts. (1) Every service plan contract of a health service plan corporation which provides that the continued coverage of a beneficiary is contingent upon the continued employment or membership of the subscriber with a particular employer, union, or association shall further provide for the right of said person to make application for an individual service plan contract under the circumstances and in accordance with the requirements set forth in Section 367d of the "Illinois Insurance Code". The application of Section 367d of the Code shall not be construed in such a manner as to require a health service plan corporation to furnish a service or kind of benefit not customarily pro-

vided by such corporation and which is inconsistent with the provision of this Act.

(2) The requirements of this Section shall apply to all such contracts delivered, issued for delivery, renewed or amended on or after 180 days following the effective date of this Section.

§ 609.10. Optometric services—Notice of election.

§ 15.10. Every service plan contract of a health service plan corporation issued after the effective date of this amendatory Act of 1979 which provides coverage for optometric services, as defined in "An Act in relation to the regulation of the practice of optometry, and to repeal an Act therein named", approved June 15, 1951, as now or hereafter amended shall, upon issuance, be accompanied by a written notice to the subscriber that such subscriber may elect for optometric services received to be reimbursed to either a physician licensed to practice medicine in all its branches or to an optometrist licensed in this State.